



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Michael Lopez, DC

Respondent Name

Praetorian Insurance Company

MFDR Tracking Number

M4-15-1526-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

January 23, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am resubmitting the claim for payment for the following reasons: THIS IS NOT A DUPLICATE CLAIM/SERVICE. All of this documentation was sent in for reconsideration to the carrier several times. This is an approved case with all other claims being paid in full. Carrier's reason for denying office visit cannot be explained by the carrier when I placed a call to them for explanation. Our office has billed for same CPT code of 99213 several times and has received payment from the carrier. Carrier paid for work status for 73, cannot have status form without an office visit. Please see attached patient account statement showing all other claims being paid in a timely manner. I'm taking the next step to get the rest of these claims paid and sending all documentation I have to MDR. THESE ARE NOT DUPLICATES. All other claims have been paid at 100%. Therefore, these claims should be paid in full."

Amount in Dispute: \$112.33

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please see the EOBs. There is an issue regarding service and provider type. The Texas Labor Code requires reimbursement for all medical expenses to be fair and reasonable and be designed to ensure the quality of medical care and to achieve effective medical cost control. TEX. LABOR CODE Section 413.011(d). Subject to further review, the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 16, 2014	Evaluation and Management (99213)	\$112.33	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for billing and reimbursing professional services.

3. 28 Texas Administrative Code §133.240 sets out the procedures for payment or denial of medical bills.
4. 22 Texas Administrative Code §78.17 defines the scope of practice for chiropractors for the disputed date of service.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 8 – The procedure code is inconsistent with the provider type/specialty (taxonomy).
 - ZE10 – Not defined as required in 28 Texas Administrative Code §133.240.

Issues

1. Are the disputed services inconsistent with the provider type/specialty of the requestor?
2. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied the billed charges, stating, “The procedure code is inconsistent with the provider type/specialty (taxonomy).” A review of the NPI number for the requestor indicates that the provider is identified as a chiropractor. 28 Texas Administrative Code §134.203 (a)(6) states, “Notwithstanding Medicare payment policies, chiropractors may be reimbursed for services provided within the scope of their practice act.”

A review of the submitted documentation finds that the disputed services involve an evaluation and management charge. Evaluation and management is included in the scope of practice for chiropractors according to 22 Texas Administrative Code §78.17. Therefore, the Division finds that the disputed services are not inconsistent with the provider type/specialty of the requestor.

2. 28 Texas Administrative Code §134.203(b)(1) states, in pertinent part, “for coding, billing reporting, and reimbursement of professional medical services, Texas Workers’ Compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; ... and other payment policies in effect on the date a service is provided...” Review of the submitted documentation finds that the requestor performed an office visit for the evaluation and management of an established patient, using CPT code 99213.

The American Medical Association (AMA) CPT code description for 99213 is:

Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: **An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity** [emphasis added]. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.

The 1997 Documentation Guidelines for Evaluation & Management Services is the applicable Medicare guideline to determine the documentation requirements for the service in dispute. Review of the documentation finds the following:

- Documentation of the Expanded Problem Focused History:
 - “A *brief* [History of Present Illness (HPI)] consists of one to three elements of the HPI [or may include the status of 1-2 chronic or inactive conditions].” Documentation found the status of one chronic condition listed, thus meeting the requirement for this element.
 - “A *problem pertinent* [Review of Systems (ROS)] inquires about the system directly related to the problem(s) identified in the HPI.” The Guidelines state, “The patient’s positive responses and pertinent negatives for the system related to the problem should be documented.” Documentation found no review of systems. This element was not met.
 - A Past Family, and/or Social History (PFSH) is not required for this component.

The Guidelines state, “To qualify for a given type of history all three elements in the table must be met.” A review of the submitted documentation indicates that this component of CPT Code 99213 was not met.
- Documentation of the Expanded Problem Focused Examination:
 - An “*expanded problem focused* [examination should include] a limited examination of the affected body area or organ system **and any other symptomatic or related body area(s) or organ system(s)**” [emphasis added]. A review of the submitted documentation finds that a limited examination was performed only for the affected body area (lumbar). Therefore, this component of CPT Code 99213 was not met.
- Documentation of Decision Making of Low Complexity:
 - *Number of diagnoses or treatment options* – Review of the submitted documentation finds that

there were no new diagnoses presented, but that the established diagnosis was stable, meeting the documentation requirements of minimal complexity. Therefore, this element was not met.

- *Amount and/or complexity of data to be reviewed* – Review of the documentation finds that the requestor ordered no new tests and reviewed no records from other sources. This meets the requirements for minimal complexity. Therefore, this element was not met.
- *Risk of complications and/or morbidity or mortality* – Review of the submitted documentation finds that presenting problems include one stable, chronic injury, which presents a low level of risk. No diagnostic procedures were ordered. Physical therapy was continued, which presents a low level of risk. “The highest level of risk in any one category...determines the overall risk.” The documentation supports that this element met the criteria for low risk. Therefore, this element was met.

“To qualify for a given type of decision making, **two of the three elements ... must be either met or exceeded.**” A review of the submitted documentation supports that this component of CPT Code 99213 was not met.

Because no components of CPT Code 99213 were met, the requestor failed to support the level of service required by 28 Texas Administrative Code §134.203. Consequently, the requestor is not entitled to additional reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	_____
Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	March 17, 2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.